

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/29/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE SENIOR LIVING CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591		
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F 000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from investigation of complaints #105144-C, #105319-C, #105324-C, #106838-C, #107305-C, 109293-A and #109300-A conducted December 5, 2022 to December 29, 2022. Complaints #106838-C, #109293-C and #109300-C were substantiated. The findings of #109293-A and #109300-A will be sent at a later date under a different cover. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	<p>Continued From page 1</p> <p>must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff, and resident interviews, the facility failed to ensure a resident's right to a dignified existence, as the facility coerced and retaliated against that resident when he attempted to exercise his rights for one of four residents reviewed. (Resident #4) The facility reported a census of 24.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment tool with Assessment Reference Date of 10/26/22, Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #4 required limited assistance with</p>	F 550			

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F 550	<p>Continued From page 2</p> <p>transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #4's diagnoses included renal insufficiency and diabetes mellitus.</p> <p>In an interview on 12/14/22 at 2:25 p.m. Resident #4 stated that when he initially admitted to the facility, he was told he could have his own room. Resident #4 stated he was skilled at that time. Later, when he was no longer skilled, the facility wanted him to move in with a roommate. Resident #4 stated he refused, noting there were empty rooms in the facility. He continued to argue with the ex-Administrator (XAdmin). After the XAdmin was fired a new Administrator took her place and insisted he had to move. Resident #4 stated they wanted to empty the rooms in other hallways. Resident #4 stated (on 8/3/22) they finally brought in the Deputy Sheriff and was told to either accept a roommate or leave. Resident #4 stated he agreed to have his friend as a roommate and then his friend backed out. Resident #4 stated that the facility staff entered his room, gathered his belongings, and escorted him out the front door. Resident #4 stated he did not have a place to go, was insulin dependent, and was not provided any medications. Resident #4 stated he called his nephew and got a ride to his ex-wife's home. That evening he fell down her steps and was taken by ambulance to the hospital. When he told his story, the hospital stated they can't just kick you out. The hospital kept him for two days, before making arrangements for him to return to the facility. Resident #4 stated he was initially returned to a small room that was so cluttered he was unable to get to his bathroom. Resident #4 stated he had to go to an empty room (32) and use that bathroom. Resident #4 stated he was later moved to room 32, where he resides today. Resident #4</p>	F 550			

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F 550	<p>Continued From page 3</p> <p>stated they had just brought in a roommate two weeks ago.</p> <p>In an interview on 12/20/22 at 3:20 p.m. the Ex-Director of Nursing (XDON) stated she was the DON from April through November 14th, 2022. The XDON stated shortly after the arrival of the new Administrator, they were directed to start moving residents in with roommates to make room for private pay residents. The XDON stated there was no waiting list for private pay residents and no immediate need for vacant rooms. The XDON stated Resident #4 did not want a roommate and argued whenever it was mentioned. On 8/3/22 the XDON again discussed with Resident #4 about getting a roommate. Resident #4 refused and the Administrator was informed. According to the XDON the Administrator went to Resident #4's room and it escalated. The Administrator returned to the nurse's station area and stated Resident #4 was leaving against medical advice (AMA) and to get the paperwork. The XDON stated that between her and the social worker (XSW) they filled out the form. The XDON stated Resident #4 was very upset. The XDON stated she was not involved with removing Resident #4's belongings. The XDON stated she was uncomfortable with how Resident #4 left and voiced her concerns to their corporate office. A zoom meeting took place and the issue was discussed with the Administrator, corporate staff, and the XDON.</p> <p>In an interview on 12/20/22 at 4:19 p.m. the Ex-Social Worker (XSW) stated the facility had several changes in management in the past year. When the current Administrator started, she almost immediately began insisting Medicaid/Medicare residents were to have</p>	F 550			

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F 550	<p>Continued From page 4</p> <p>roommates. The XSW stated she did not understand why the Administrator was pushing for roommates since several of the residents had been in rooms for a long time and they had several vacant rooms. The Administrator instructed the XSW to start giving 30 day eviction notices, which included Resident #4. The XSW stated she was able to assist some residents with alternative placement, but could not find placement for Resident #4. On 8/3/22 the roommate issue came up again. Resident #4 did not understand why he needed a roommate. The Administrator and the XSW went to Resident #4's room. Resident #4 was asking why he had to have a roommate and the Administrator began yelling at him, stating you are getting a roommate or leaving AMA, what is it going to be. The Administrator would not allow Resident #4 to speak and keep saying what is it going to be, roommate or AMA. Resident #4 got so upset he finally said I'm leaving. The Administrator said fine, have him sign the papers. The XSW stated the maintenance guy gathered his belongings, sat them outside the front door and Resident #4 was escorted out. The XSW stated the Deputy Sheriff was present and escorted Resident #4 to the front door.</p> <p>According to a Social Services Note dated 8/3/22 and written by the XSW, Housekeeping went to let Resident #4 know she was going to rearrange his items to his side of the room and one side of the closet and Resident #4 was not very happy, got loud in the lobby and threatened to leave and then said by law it is our right to find him a place to live that he likes. The XSW told him if he was to walk out it was not our responsibility to find him placement.</p>	F 550			

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F 550	<p>Continued From page 5</p> <p>In an interview on 12/21/22 at 10:53 a.m. the Local Deputy Sheriff (LDS) stated on 8/3/22 he was called to the facility to intervene and keep the peace regarding a tenant dispute with the facility. Two residents, Resident #4 and Resident #5 were being asked to share a room to allow room for a pending admission from the hospital. Resident #4 was very upset and given the choice to either share a room or leave AMA. LDS stated it was obvious Resident #4 did not want to leave, but he felt he had no choice. The LDS stated the staff entered his room, placed his belongings into trash bags and escorted Resident #4 in his wheelchair, with his belongings to the front of the building and left him. The LDS stated Resident #4 called a friend and went to his home in Arson where his wife lives, who is in the process of divorcing. The LDS stated he did not feel it was right that a facility could force a resident onto the streets with no place to go.</p> <p>In an interview on 12/21/22 at 12:08 p.m. the Administrator was asked if she recalled her conversation with Resident #4 on 8/3/22. The Administrator asked if that was the day Resident #4 left AMA? The Administrator then stated she was Resident #4's niece by marriage, so she usually would have someone else talk to him. The Administrator stated she did not recall the conversation she had with him that day. The Administrator was asked if she remembered why it was necessary for Resident #4 to share a room. The Administrator stated she did not recall, noting that was a long time ago.</p> <p>In a statement on 12/20/22 at 5:12 p.m. during a phone call, the facilities Corporate Manager indicated she was unable to locate an AMA form related to Resident #4's discharge on 8/3/22.</p>	F 550			

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F 550	Continued From page 6	F 550			
F 580 SS=D	<p>According to a progress note dated 8/3/22 at 12:00 p.m. and written by the XDON, Resident #4 and his belongings were discharged AMA and he had someone to pick him up.</p> <p>Notify of Changes (Injury/Denial/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p>	F 580			

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F 580	<p>Continued From page 7</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews, the facility failed to consult a resident's physician or notify the family of a resident's persistent and excruciating headache, motor skill decline, and mental status change in a timely manner. (Resident #1) The facility reported a census of 24.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment tool with Assessment Reference Date of 10/20/22, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, indicating a moderately impaired cognition. Resident #1 required limited assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #1's diagnoses included coronary artery disease, congestive heart failure, hypertension, and psychotic</p>	F 580			

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F 580	<p>Continued From page 8 disorder.</p> <p>In an interview on 12/5/22 at 3:14 p.m. Staff A, Certified Nurse Aide (CNA), stated that on Tuesday, 11/29/22 she worked a 6:00 a.m. to 2:00 p.m. shift. That morning, Resident #1 was already up in her recliner, this was unusual as Resident #1 usually slept in until 9:00 a.m. to 10:00 a.m. Resident #1 was complaining of a headache and constantly pulling on her call light. At 6:15 a.m. Staff A reported Resident #1's complaints of a severe headache to the charge nurse who happened to also be the Administrator. The Administrator stated Resident #1 had already been given pain medication. Staff A asked the Administrator if the facility had ice packs and was told no, so Staff A got some wet washcloths and placed them on Resident #1's neck and head. Staff A stated the wet cloths helped briefly, but Resident #1 was back on her call light. One minute wanting in her bed and the next wanting back in her recliner. Staff A attempted to comfort her and told her they had given her medication that morning, but Resident #1 did not recall getting the medication. Staff A stated Resident #1 was usually cognitively alert, could carry on a conversation, was independent with most care, and could walk independently using her walker. Resident #1 was also a nurse. Resident #1 continued to complain of a severe headache and Staff A stated she continued to report to the Administrator that Resident #1 was having an excruciating headache and requesting to be sent to the hospital. Staff A indicated the Administrator seemed more interested in cleaning and organizing the medication room than attending to the resident. By 12:00 p.m. to 12:30 p.m. Resident #1 became even more agitated and was yelling she needed to go to the hospital. Her</p>	F 580			

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F 580	<p>Continued From page 9</p> <p>outbursts were so disruptive that residents including Resident #2 and Resident #3, were also commenting to the Administrator that Resident #1 was crying and wanting to go to the hospital. Staff A stated Resident #1 was crying in pain and stated I was a nurse and this is not normal. Staff A stated Staff B and Staff C also witnessed Resident #1's cries for help that day, but nothing was done. Staff A stated she returned to work at 5:30 a.m. the following day (11/30/22). In report, the night aide reported Resident #1 continued to complain of pain and rolled out of bed. Resident #1 was not disturbed once she seemed to calm down. At around 6:20 a.m. Staff A checked on Resident #1. Resident #1 was soaked in urine from her shoulders to her knees. The nurse, Staff E witnessed the residents lack of care and instructed Staff A to give her a bed bath. Staff A stated once she began attending to Resident #1 she knew immediately that she had had a stroke. Resident #1 was unable to talk or move her right side. There was nothing in her eyes, she was like a vegetable. Staff E had an order for a urinalysis and she assisted him with getting the urine sample. Staff A commented, I believe she has had a stroke and Staff E responded maybe. Staff A stated she changed Resident #1's bed three times that day and Resident #1 never showed any signs of improvement. Staff A stated on Monday, 11/28/22, Resident #1 was up, independent and in the dining room talking and normal and by Wednesday, 11/30/22 she was a vegetable.</p> <p>On 12/7/22 at 8:45 a.m. Staff A was contacted for clarification. Staff A stated that she gave a report to the on-coming aide (Staff G) at 2:00 p.m. on 11/29/22. Staff A stated she informed Staff G that Resident #1 had been up all night and</p>	F 580			

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F 580	<p>Continued From page 10</p> <p>complained of a severe headache throughout the day. Staff A stated Resident #1 was requesting to go to the hospital. Staff A explained that the Administrator knew of her condition and Resident #1's request to go to the hospital.</p> <p>In an interview on 12/5/22 at 4:55 p.m. Staff B, CNA, stated that she worked 6:00 a.m. to 2:00 p.m. on Monday, 11/28/22. Staff B stated she remembered Resident #1 being alert, conversing with staff, independently mobile using her walker, and being her normal self. Resident #1 only needed assistance with incontinence cares. On Tuesday, 11/29/22, Staff B worked from 6:00 a.m. until 2:00 p.m. That morning when she arrived, Resident #1 was complaining of a headache. As the morning progressed, Resident #1's headache worsened into a migraine. Resident #1 began requesting to be sent to the hospital. The Administrator stated they had already given her something and stated that is just Resident #1 she complains, but she is fine. Staff B stated she never saw the Administrator check on Resident #1. Resident #1 continued to complain of an excruciating headache and continually pulled on her call light throughout her shift. Resident #1 would say I was a nurse, I know they can help me, but no one did.</p> <p>On 12/7/22 at 11:50 a.m. Staff B was interviewed for clarification. Staff B stated when she spoke with the Administrator about Resident #1, she informed her that Resident #1 was requesting to go to the hospital. At that time the Administrator said she already gave her something for pain. The Administrator added that she complains, but she is fine.</p> <p>In an interview on 12/5/22 at 5:10 p.m. Staff C,</p>	F 580			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/29/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE SENIOR LIVING CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH STONE STREET SIGOURNEY, IA 52591		
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F 580	<p>Continued From page 11</p> <p>Marketing, stated she arrived to work around 8:30 a.m. on 11/29/22. Several of the aides approached her with concerns related to Resident #1. The aides stated Resident #1 was complaining of an excruciating headache and requesting to go to the hospital. The aides indicated they had informed the Administrator several times, but she was doing nothing. Staff C stated she went to the Administrator and expressed her concern. The Administrator stated she had given Resident #1 a Tramadol (controlled pain medication) and they were getting an order for a urinalysis. Staff C stated that the Administrator never saw or assessed Resident #1 that day. Staff C stated that afternoon Resident #1 was grabbing at her head and screaming. Resident #1 wanted to go to the hospital. Staff C stated Resident #1 had been cognitively alert most of the day complaining of a headache, but by late that afternoon her speech had become garbled. She was not alert and confused. On Wednesday, 11/30/22, Resident #1's right side was flaccid, she was unresponsive, and she had no right side vision. Staff C stated to her knowledge no one ever properly assessed Resident #1 or sought appropriate medical attention.</p> <p>On 12/7/22 at 8:08 a.m. Staff C was contacted for clarification. Staff C stated she included Resident #1's requesting to go to the hospital when informing the Administrator of Resident 1's condition that day and also reported late that afternoon when Resident #1's speech became garbled and she became confused.</p> <p>In an interview on 12/6/22 at 11:05 a.m. Staff D, Certified Medication Aide, stated she worked 6:00 a.m. to 2:00 p.m. on 11/29/22 and was assigned</p>	F 580			

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F 580	Continued From page 12 to pass medications. The scheduled nurse called in so the Administrator covered for the absent nurse. Staff D stated the Administrator remained in the medication room cleaning and organizing her entire shift. Staff D stated she started setting up medications when Resident #1's call light came on, so she responded. Resident #1 was complaining of a headache. Staff D assisted Resident #1 to the toilet. Resident #1 was having difficulties walking which was unusual for her. Staff D got Resident #1 to the toilet and returned to her medication cart. The call light came on again and Staff D returned and helped Resident #1 into her recliner, gave her a blanket. Moments later Resident #1 was hollering for help. Staff D gave her Tylenol at 7:14 a.m. and then again returned to her cart as Resident #1 continued to holler out and cry for help. Other aides voiced concerns. At around 9:00 a.m. Staff D asked the Administrator to check on Resident #1. Staff D stated the Administrator never checked on Resident #1 during her shift, despite being informed, and asked multiple times. Staff D stated she felt helpless because the Administrator would not do anything. Staff D stated she was on the assisted living unit setting up medications from about 10:00 a.m. until 12:00 p.m. Upon returning, Resident #1 was continuing to cry out in pain. Staff D said something to the Administrator and she was instructed to give Resident #1 Tramadol at 11:48 a.m. Staff D stated the Administrator did not assess Resident #1 prior to or after the administration of the controlled medication. The next day (11/30/22) an aide reported something was wrong with Resident #1. Staff D went to the room. Resident #1 was sitting in bed awake but not responsive, would not talk, and would not move. Resident #1 would not take her medications. Staff D reported	F 580			

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F 580	<p>Continued From page 13</p> <p>her observations to Staff E. The Administrator was standing nearby, listening to the conversation, then stated the urinalysis was sent. And that she was fine. Staff F stated Staff E went to check on Resident #1.</p> <p>In an interview on 12/6/22 at 5:00 p.m. the Administrator stated on 11/29/22 the day nurse called in, so she took on the responsibilities of the licensed nurse from 6:00 a.m. to 6:00 p.m. The Administrator admitted she does not work the floor and was not familiar with the residents. The Administrator stated Resident #1 had a headache, was confused, and not acting right that day. Resident #1 was given as needed pain medication and the Administrator personally gave her pain medication at 6:02 p.m. The Administrator stated at one time that day (unable to specify the time of day) she noticed Resident #1's oxygen tubing knotted. She corrected it and checked the oxygen saturation which was at 91%-92%. The Administrator stated at 2:00 p.m. Staff D left, then at 6:00 p.m. Staff F arrived and took over the nursing duties. The Administrator was asked if anyone had approached her that day with concerns about Resident #1? The Administrator stated yes, they all thought she had COVID. They told her Resident #1 had a headache. The Administrator was asked if anyone told her Resident #1 wanted to go to the hospital? The Administrator stated no, if they had I would have sent her. The Administrator stated she never charted an assessment on Resident #1, consulted a physician, or notified family of Resident #1's condition.</p> <p>According to the Centers for Disease Control and Prevention (CDC) information on Stroke Signs and Symptoms dated March 4, 2022:</p>	F 580			

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F 580	<p>Continued From page 14</p> <p>During a stroke every minute counts, fast treatment can lessen the brain damage that stroke can cause.</p> <p>By knowing the signs and symptoms of a stroke, you can take quick action and perhaps save a life.</p> <p>Signs and symptoms of stroke include:</p> <ul style="list-style-type: none"> *Sudden numbness or weakness in the face, arm, or leg, especially on one side of the body. *Sudden confusion, trouble speaking, or difficulty understanding speech. *Sudden trouble seeing in one or both eyes. *Sudden trouble walking, dizziness, loss of balance, or lack of coordination. *Sudden severe headache with no known cause. <p>Call 9-1-1 right away if you or someone else has any of these symptoms.</p> <p>According to the facilities undated Licensed Vocational Nurse Position Description (LPN), licensed nurses are responsible for:</p> <ul style="list-style-type: none"> *Observes residents, records significant conditions and reactions, notifies supervisor or physician of resident's conditions and reactions to drugs, treatments and significant incidents. <p>In an interview on 12/8/22 at 12:50 a.m. Staff F, Licensed Practical Nurse, stated if the residents have a change in condition, they should be assessed, have vitals checked, and a physician notified. The assessment should be documented in the progress notes. Staff F stated she thought Resident #1's change in condition had already been reported during the day shift on 11/29/22.</p> <p>In an interview on 12/8/22 at 4:42 p.m. Staff E, Licensed Practical Nurse, was informed that according to other caregivers on 11/29/22, Resident #1 had had an excruciating headache,</p>	F 580			

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F 580	<p>Continued From page 15</p> <p>unrelieved with medication throughout the day. She was continually on her call light and requesting to go to the hospital. Staff E stated Resident #1 pulling on her call light or having a headache was not unusual, but not getting relief of her headache after given medication was unusual. Staff E stated he would have assessed Resident #1 and discussed what they could do to relieve her headache. If symptoms persisted he would notify the physician and have her sent out.</p> <p>In an interview on 12/6/22 at 10:05 a.m. ARNP1, Nurse Practitioner, stated on 11/30/22 she visited the facility in response to Resident #1's change in condition. ARNP1 stated this was the first time she had ever seen Resident #1 and she was not familiar with the residents past abilities and condition. ARNP1 stated she was informed by Staff E that Resident #1 had become incontinent and her urine was foul smelling. Staff E stated Resident #1 gets confused when she has a urinary tract infection. ARNP1 stated she seen Resident #1 sitting at her bedside, restless, and unable to respond appropriately when spoken to. ARNP1 stated she spoke with her family who indicated they did not want Resident #1 sent to the hospital. The family indicated the resident would not want to go to the hospital. ARNP1 stated she had not been informed that Resident #1 had an excruciating headache throughout the day on 11/29/22 and that Resident #1 was requesting to go to the hospital. ARNP1 stated she did not know that prior to yesterday, Resident #1 was cognitively alert, verbal, and independently mobile using her walker. ARNP1 asked if she had been contacted about a resident having an excruciating headache, crying and requesting to go to the hospital, would she send the resident? ARNP1 stated if the resident was</p>	F 580			

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F 580	<p>Continued From page 16</p> <p>cognitively aware, she would not hesitate to send her to the hospital. ARNP1 asked if a resident were having an excruciating headache 24 hours before she had an adverse condition change (stroke), would there have been any benefit to sending the resident to the hospital prior to those adverse changes. ARNP1 stated yes, there are medications which can slow the progression of a stroke down.</p> <p>In an interview on 12/7/22 at 11:30 a.m. the Director of Nursing (DON) stated residents with complaints or changes in condition are to be thoroughly assessed, treated, and documented in the progress notes. If a complaint persists or is a significant change, nurses are to contact a physician and treat accordingly. Families are also to be notified and then documented in the progress notes.</p> <p>In an interview on 12/7/22 at 3:25 p.m. Staff I, Licensed Practical Nurse, stated she works for an agency. Staff I stated that when a resident has a complaint or change in condition, they are to be assessed, including checking vital signs, rating pain, and administering as needed (PRN) medications when appropriate. The assessment should be recorded in the progress notes. If the change in condition is significant or an emergency type situation, she would first attend to the resident's needs, consult a physician, and notify emergency medical services (EMS) if appropriate. Following the event she would record the assessment and contact details in the progress notes or on an incident report form. Staff I stated she would notify family and record the communication in the progress notes.</p> <p>In an interview on 12/13/22 at 9:33 a.m. Resident</p>	F 580			

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F 580	Continued From page 17 #1's son and Power of Attorney (POA), indicated he was first contacted by the facility on 11/30/22 by Staff E. He was informed at that time that his mother was not feeling well and they thought it might be a bladder infection. Later that same day they reported the lab was negative and they thought that she had a stroke. The son stated he was recently told by an aide who had since quit that she felt his mother was not cared for properly. The son was informed that according to multiple caregivers working on 11/29/22, his mother was having an excruciating headache that day and at some point started requesting to be sent to the hospital. The headache, motor skill changes, and mental status changes were all signs of a stroke. Based on the Department of Inspections and Appeals investigation, the nurse that day failed to take appropriate action including not consulting a physician or notifying family. The son was grateful for the information and stated had he known he may have agreed to have his mother sent to the hospital.	F 580			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622			

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F 622	<p>Continued From page 18</p> <p>endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record</p>	F 622			

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F 622	<p>Continued From page 19</p> <p>must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record reviews, staff, and resident interviews the facility failed to allow a resident to remain in the facility unless that resident agreed to having a roommate, despite multiple vacant rooms available and no pending admissions. The facility badgered and coerced</p>	F 622			

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F 622	<p>Continued From page 20</p> <p>the resident into leaving under the premise until he left voluntarily and against medical advice (AMA) for one of four residents reviewed. (Resident #4) The facility reported a census of 24.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment tool with assessment reference date of 10/26/22, Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #4 required limited assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #4's diagnoses included renal insufficiency and diabetes mellitus.</p> <p>According to the facilities Transfer and/or Discharge, Including Against Medical Advice (AMA) policy Guidelines revised October 2022 the community will permit a resident to remain in the community, and not transfer or discharge the resident from the community unless:</p> <ul style="list-style-type: none"> a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility; b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; d. The health of individuals in the facility would otherwise be endangered; e. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; f. An immediate transfer or discharge is required 	F 622			

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F 622	Continued From page 21 by the resident's urgent medical needs; g. The facility ceases to operate. If the need arises, address with residents and if appropriate their representative, that leaving against medical advice is not in their best interest. Except in conditions listed above, the community may issue a resident, and/or his representative a thirty (30)-day advanced notice of an impending transfer or discharge from our facility. The resident may not be transferred or discharged while an appeal of such is in place or unless failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the community. This danger will be documented in the medical record. The resident and/or representative will be provided the following information within the notice, in writing and language and manner they understand, prior to transfer: - The reason for the transfer or discharge, and reasons for the move in writing and in language and manner they understand; - Send a copy of the notice to the State Long Term Ombudsman, note in record; - The effective date of transfer or discharge; - Reason for the transfer; - A statement of the resident's appeals rights, including the name, address and telephone number of the entity which receives such requests; and information on how to obtain the appeal form and assistance in completing the form and submitting the appeal hearing request. - The name, address, and telephone number of the state long term ombudsman; - The name, address, mailing and email address and telephone number of each advocacy or mentally ill or developmental disabled individuals as applies; and - The name, address, mailing and email address	F 622			

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F 622	<p>Continued From page 22</p> <p>and telephone number of the state health department agency that has been designated to handle appeals or transfers and discharge notices.</p> <p>In an interview on 12/14/22 at 2:25 p.m. Resident #4 stated that when he initially admitted to the facility, he was told he could have his own room. Resident #4 stated he was skilled at that time. Later, when he was no longer skilled, the facility wanted him to move in with a roommate. Resident #4 stated he refused, noting there were empty rooms in the facility. He continued to argue with the ex-Administrator (XAdmin). After the XAdmin was fired a new Administrator took her place and insisted he had to move. Resident #4 stated they wanted to empty the rooms in other hallways. Resident #4 stated (on 8/3/22) they finally brought in the Deputy Sheriff and was told to either accept a roommate or leave. Resident #4 stated he agreed to have his friend as a roommate and then his friend backed out. Resident #4 stated that the facility staff entered his room, gathered his belongings, and escorted him out the front door. Resident #4 stated he did not have a place to go, was insulin dependent, and was not provided any medications. Resident #4 stated he called his nephew and got a ride to his ex-wife's home. That evening he fell down her steps and was taken by ambulance to the hospital. When he told his story, the hospital stated they can't just kick you out. The hospital kept him for two days, before making arrangements for him to return to the facility. Resident #4 stated he was initially returned to a small room that was so cluttered he was unable to get to his bathroom. Resident #4 stated he had to go to an empty room (32) and use that bathroom. Resident #4 stated he was later moved</p>	F 622			

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F 622	<p>Continued From page 23</p> <p>to room 32, where he resides today. Resident #4 stated they had just brought in a roommate two weeks ago.</p> <p>In an interview on 12/20/22 at 3:20 p.m. the Ex-Director of Nursing (XDON) stated she was the DON from April through November 14th, 2022. The XDON stated shortly after the arrival of the new Administrator, they were directed to start moving residents in with roommates to make room for private pay residents. The XDON stated there was no waiting list for private pay residents and no immediate need for vacant rooms. The XDON stated Resident #4 did not want a roommate and argued whenever it was mentioned. On 8/3/22 the XDON again discussed with Resident #4 about getting a roommate. Resident #4 refused and the Administrator was informed. According to the XDON the Administrator went to Resident #4's room and it escalated. The Administrator returned to the nurse's station area and stated Resident #4 was leaving against medical advice (AMA) and to get the paperwork. The XDON stated that between her and the social worker (XSW) they filled out the form. The XDON stated Resident #4 was very upset. The XDON stated she was not involved with removing Resident #4's belongings. The XDON stated she was uncomfortable with how Resident #4 left and voiced her concerns to their corporate office. A zoom meeting took place and the issue was discussed with the Administrator, corporate staff, and the XDON.</p> <p>In an interview on 12/20/22 at 4:19 p.m. the Ex-Social Worker (XSW) stated the facility had several changes in management in the past year. When the current Administrator started, she almost immediately began insisting</p>	F 622			

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F 622	<p>Continued From page 24</p> <p>Medicaid/Medicare residents were to have roommates. The XSW stated she did not understand why the Administrator was pushing for roommates since several of the residents had been in rooms for a long time and they had several vacant rooms. The Administrator instructed the XSW to start giving 30 day eviction notices, which included Resident #4. The XSW stated she was able to assist some residents with alternative placement, but could not find placement for Resident #4. On 8/3/22 the roommate issue came up again. Resident #4 did not understand why he needed a roommate. The Administrator and the XSW went to Resident #4's room. Resident #4 was asking why he had to have a roommate and the Administrator began yelling at him, stating you are getting a roommate or leaving AMA, what is it going to be. The Administrator would not allow Resident #4 to speak and keep saying what is it going to be, roommate or AMA. Resident #4 got so upset he finally said I'm leaving. The Administrator said fine, have him sign the papers. The XSW stated the maintenance guy gathered his belongings, sat them outside the front door and Resident #4 was escorted out. The XSW stated the Deputy Sheriff was present and escorted Resident #4 to the front door.</p> <p>According to a Social Services Note dated 8/3/22 and written by the XSW, Housekeeping went to let Resident #4 know she was going to rearrange his items to his side of the room and one side of the closet and Resident #4 was not very happy, got loud in the lobby and threatened to leave and then said by law it is our right to find him a place to live that he likes. The XSW told him if he was to walk out it was not our responsibility to find him placement.</p>	F 622			

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F 622	<p>Continued From page 25</p> <p>In an interview on 12/21/22 at 10:53 a.m. the Local Deputy Sheriff (LDS) stated on 8/3/22 he was called to the facility to intervene and keep the peace regarding a tenant dispute with the facility. Two residents, Resident #4 and Resident #5 were being asked to share a room to allow room for a pending admission from the hospital. Resident #4 was very upset and given the choice to either share a room or leave AMA. LDS stated it was obvious Resident #4 did not want to leave, but he felt he had no choice. The LDS stated the staff entered his room, placed his belongings into trash bags and escorted Resident #4 in his wheelchair, with his belongings to the front of the building and left him. The LDS stated Resident #4 called a friend and went to his home in Arson where his wife lives, who is in the process of divorcing. The LDS stated he did not feel it was right that a facility could force a resident onto the streets with no place to go.</p> <p>In an interview on 12/21/22 at 12:08 p.m. the Administrator was asked if she recalled her conversation with Resident #4 on 8/3/22. The Administrator asked if that was the day Resident #4 left AMA? The Administrator then stated she was Resident #4's niece by marriage, so she usually would have someone else talk to him. The Administrator stated she did not recall the conversation she had with him that day. The Administrator was asked if she remembered why it was necessary for Resident #4 to share a room. The Administrator stated she did not recall, noting that was a long time ago.</p> <p>In a statement on 12/20/22 at 5:12 p.m. during a phone call, the facilities Corporate Manager indicated she was unable to locate an AMA form</p>	F 622			

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F 622	Continued From page 26 related to Resident #4's discharge on 8/3/22.	F 622			
F 623 SS=D	<p>According to a progress note dated 8/3/22 at 12:00 p.m. and written by the XDON, Resident #4 and his belongings were discharged AMA and he had someone to pick him up.</p> <p>Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)</p> <p>§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <ul style="list-style-type: none"> (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. <p>§483.15(c)(4) Timing of the notice.</p> <ul style="list-style-type: none"> (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- <ul style="list-style-type: none"> (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would 	F 623			

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F 623	<p>Continued From page 27</p> <p>be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental</p>	F 623			

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F 623	<p>Continued From page 28</p> <p>disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to provide a resident adequate notice and documentation prior to their discharge for one of four residents reviewed. (Resident #4) The facility reported a census of 24.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment tool with Assessment Reference Date of 10/26/22, Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12,</p>	F 623			

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F 623	<p>Continued From page 29</p> <p>indicating moderately impaired cognition. Resident #4 required limited assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #4's diagnoses included renal insufficiency and diabetes mellitus.</p> <p>According to the facilities Transfer and/or Discharge, Including Against Medical Advice (AMA) policy Guidelines revised October 2022 the community will permit a resident to remain in the community, and not transfer or discharge the resident from the community unless:</p> <ul style="list-style-type: none"> a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility; b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; d. The health of individuals in the facility would otherwise be endangered; e. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; f. An immediate transfer or discharge is required by the resident's urgent medical needs; g. The facility ceases to operate. <p>If the need arises, address with residents and if appropriate their representative, that leaving against medical advice is not in their best interest. Except in conditions listed above, the community may issue a resident, and/or his representative a thirty (30)-day advanced notice of an impending transfer or discharge from our facility. The resident may not be transferred or discharged while an appeal of such is in place or unless failure to discharge or transfer would</p>	F 623			

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F 623	<p>Continued From page 30</p> <p>endanger the health or safety of the resident or other individuals in the community. This danger will be documented in the medical record. The resident and/or representative will be provided the following information within the notice, in writing and language and manner they understand, prior to transfer:</p> <ul style="list-style-type: none"> - The reason for the transfer or discharge, and reasons for the move in writing and in language and manner they understand; - Send a copy of the notice to the State Long Term Ombudsman, note in record; - The effective date of transfer or discharge; - Reason for the transfer; - A statement of the resident's appeals rights, including the name, address and telephone number of the entity which receives such requests; and information on how to obtain the appeal form and assistance in completing the form and submitting the appeal hearing request. - The name, address, and telephone number of the state long term ombudsman; - The name, address, mailing and email address and telephone number of each advocacy or mentally ill or developmental disabled individuals as applies; and - The name, address, mailing and email address and telephone number of the state health department agency that has been designated to handle appeals or transfers and discharge notices. <p>In an interview on 12/14/22 at 2:25 p.m. Resident #4 stated that when he initially admitted to the facility, he was told he could have his own room. Resident #4 stated he was skilled at that time. Later, when he was no longer skilled, the facility wanted him to move in with a roommate. Resident #4 stated he refused, noting there were</p>	F 623			

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F 623	<p>Continued From page 31</p> <p>empty rooms in the facility. He continued to argue with the ex-Administrator (XAdmin). After the XAdmin was fired a new Administrator took her place and insisted he had to move. Resident #4 stated they wanted to empty the rooms in other hallways. Resident #4 stated (on 8/3/22) they finally brought in the Deputy Sheriff and was told to either accept a roommate or leave. Resident #4 stated he agreed to have his friend as a roommate and then his friend backed out. Resident #4 stated that the facility staff entered his room, gathered his belongings, and escorted him out the front door. Resident #4 stated he did not have a place to go, was insulin dependent, and was not provided any medications. Resident #4 stated he called his nephew and got a ride to his ex-wife's home. That evening he fell down her steps and was taken by ambulance to the hospital. When he told his story, the hospital stated they can't just kick you out. The hospital kept him for two days, before making arrangements for him to return to the facility. Resident #4 stated he was initially returned to a small room that was so cluttered he was unable to get to his bathroom. Resident #4 stated he had to go to an empty room (32) and use that bathroom. Resident #4 stated he was later moved to room 32, where he resides today. Resident #4 stated they had just brought in a roommate two weeks ago.</p> <p>In an interview on 12/20/22 at 3:20 p.m. the Ex-Director of Nursing (XDON) stated she was the DON from April through November 14th, 2022. The XDON stated shortly after the arrival of the new Administrator, they were directed to start moving residents in with roommates to make room for private pay residents. The XDON stated there was no waiting list for private pay residents</p>	F 623			

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F 623	<p>Continued From page 32</p> <p>and no immediate need for vacant rooms. The XDON stated Resident #4 did not want a roommate and argued whenever it was mentioned. On 8/3/22 the XDON again discussed with Resident #4 about getting a roommate. Resident #4 refused and the Administrator was informed. According to the XDON the Administrator went to Resident #4's room and it escalated. The Administrator returned to the nurse's station area and stated Resident #4 was leaving against medical advice (AMA) and to get the paperwork. The XDON stated that between her and the social worker (XSW) they filled out the form. The XDON stated Resident #4 was very upset. The XDON stated she was not involved with removing Resident #4's belongings. The XDON stated she was uncomfortable with how Resident #4 left and voiced her concerns to their corporate office. A zoom meeting took place and the issue was discussed with the Administrator, corporate staff, and the XDON.</p> <p>In an interview on 12/20/22 at 4:19 p.m. the Ex-Social Worker (XSW) stated the facility had several changes in management in the past year. When the current Administrator started, she almost immediately began insisting Medicaid/Medicare residents were to have roommates. The XSW stated she did not understand why the Administrator was pushing for roommates since several of the residents had been in rooms for a long time and they had several vacant rooms. The Administrator instructed the XSW to start giving 30 day eviction notices, which included Resident #4. The XSW stated she was able to assist some residents with alternative placement, but could not find placement for Resident #4. On 8/3/22 the roommate issue came up again. Resident #4 did</p>	F 623			

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F 623	<p>Continued From page 33</p> <p>not understand why he needed a roommate. The Administrator and the XSW went to Resident #4's room. Resident #4 was asking why he had to have a roommate and the Administrator began yelling at him, stating you are getting a roommate or leaving AMA, what is it going to be. The Administrator would not allow Resident #4 to speak and keep saying what is it going to be, roommate or AMA. Resident #4 got so upset he finally said I'm leaving. The Administrator said fine, have him sign the papers. The XSW stated the maintenance guy gathered his belongings, sat them outside the front door and Resident #4 was escorted out. The XSW stated the Deputy Sheriff was present and escorted Resident #4 to the front door.</p> <p>According to a Social Services Note dated 8/3/22 and written by the XSW, Housekeeping went to let Resident #4 know she was going to rearrange his items to his side of the room and one side of the closet and Resident #4 was not very happy, got loud in the lobby and threatened to leave and then said by law it is our right to find him a place to live that he likes. The XSW told him if he was to walk out it was not our responsibility to find him placement.</p> <p>In an interview on 12/21/22 at 10:53 a.m. the Local Deputy Sheriff (LDS) stated on 8/3/22 he was called to the facility to intervene and keep the peace regarding a tenant dispute with the facility. Two residents, Resident #4 and Resident #5 were being asked to share a room to allow room for a pending admission from the hospital. Resident #4 was very upset and given the choice to either share a room or leave AMA. LDS stated it was obvious Resident #4 did not want to leave, but he felt he had no choice. The LDS stated the staff</p>	F 623			

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F 623	Continued From page 34 entered his room, placed his belongings into trash bags and escorted Resident #4 in his wheelchair, with his belongings to the front of the building and left him. The LDS stated Resident #4 called a friend and went to his home in Arson where his wife lives, who is in the process of divorcing. The LDS stated he did not feel it was right that a facility could force a resident onto the streets with no place to go. In an interview on 12/21/22 at 12:08 p.m. the Administrator was asked if she recalled her conversation with Resident #4 on 8/3/22. The Administrator asked if that was the day Resident #4 left AMA? The Administrator then stated she was Resident #4's niece by marriage, so she usually would have someone else talk to him. The Administrator stated she did not recall the conversation she had with him that day. The Administrator was asked if she remembered why it was necessary for Resident #4 to share a room. The Administrator stated she did not recall, noting that was a long time ago. In a statement on 12/20/22 at 5:12 p.m. during a phone call, the facilities Corporate Manager indicated she was unable to locate an AMA form related to Resident #4's discharge on 8/3/22. According to a progress note dated 8/3/22 at 12:00 p.m. and written by the XDON, Resident #4 and his belongings were discharged AMA and he had someone to pick him up.	F 623			
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677			

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F 677	<p>Continued From page 35</p> <p>services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record reviews, resident, and staff interviews, the facility failed to ensure residents were provided bathing opportunities in accordance with professional standards to maintain good personal hygiene for 3 of 3 residents who could not carry out the activity independently. (Resident #4, #6, #7) The facility reported a census of 24.</p> <p>Findings include:</p> <p>In an interview on 12/29/22 at 12:30 p.m. Staff M, Certified Nurse Aide, stated she was the shower aide Monday through Thursday, when she worked, unless there were only two aides scheduled. Then she would have to work the floor and showers would not get done. Staff M stated today she was one of two aides working and showers were not getting done. Staff M stated the staff document showers in the electronic medical records (EMR). When entries have a NA in them or are left blank, it indicates the resident did not get a shower that day.</p> <p>According to the Minimum Data Set (MDS) assessment tool with Assessment Reference Date of 10/26/22, Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #4 required limited assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #4's diagnoses included renal insufficiency and diabetes mellitus.</p> <p>In an interview on 12/29/22 at 12:00 p.m.</p>	F 677			

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F 677	<p>Continued From page 36</p> <p>Resident #4 stated he believed the residents should be allowed to shower as often as they wanted. Resident #4 stated he has not had a shower in a week and rarely gets a shower twice a week.</p> <p>According to the EMR bathing records, Resident #4 appeared to be scheduled for showers on Mondays and Thursdays. In the last 60 days, Resident #4 missed 5 shower opportunities and last had a shower 1 week ago (12/22/22).</p> <p>According to the Minimum Data Set (MDS) assessment tool with Assessment Reference Date of 10/7/22, Resident #6 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #6 required extensive assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #6's diagnoses included non-Alzheimer's dementia and a seizure disorder.</p> <p>In an interview on 12/27/22 at 12:30 p.m. Resident #6 indicated she did not always get her showers.</p> <p>According to the EMR bathing records, Resident #6 should receive showers on Mondays and Thursdays. The EMR indicated Resident #6 did not receive a shower on 11/7, 11/24, and 12/19 during the last 60 days.</p> <p>According to the Minimum Data Set (MDS) assessment tool with Assessment Reference Date of 12/2/22, Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Resident #7 required limited assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs.</p>	F 677			

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F 677	Continued From page 37 Resident #7's diagnoses included bipolar disorder, schizophrenia, paralytic gait, chronic obstructive pulmonary disease, and a seizure disorder. In an interview on 12/27/22 at 12:00 p.m. Resident #7 reported being frustrated with not getting his showers, noting he was lucky if he received one shower a week. According to the EMR bathing records, Resident #7 has only had three recorded showers in the past 30 days since his admission on 11/28/22.	F 677			
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews, the facility failed to complete a comprehensive assessment on a resident with a persistent and excruciating headache, motor skill decline, and a change in mental status for one of four residents reviewed (Resident #1). Due to the lack of a comprehensive assessment for Resident #1, this resulted in an Immediate Jeopardy incident. On December 7, 2022 at 3:00 PM, the Iowa Department of Inspections and Appeals notified the facility of the Immediate	F 684			

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F 684	<p>Continued From page 38</p> <p>Jeopardy. The facility reported a census of 24.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment tool with an Assessment Reference Date of 10/20/22, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. Resident #1 required limited assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #1's diagnoseis included coronary artery disease, congestive heart failure, hypertension, and psychotic disorder.</p> <p>In an interview on 12/5/22 at 3:14 p.m. Staff A, Certified Nurse Aide (CNA), stated that on Tuesday, 11/29/22 she worked a 6:00 a.m. to 2:00 p.m. shift. That morning, Resident #1 was already up in her recliner, this was unusual as Resident #1 usually slept in until 9:00 a.m. to 10:00 a.m. Resident #1 was complaining of a headache and constantly pulling on her call light. At 6:15 a.m. Staff A reported Resident #1's complaints of a severe headache to the charge nurse who happened to also be the Administrator. The Administrator stated Resident #1 had already been given pain medication. Staff A asked the Administrator if the facility had ice packs and was told no, so Staff A got some wet washcloths and placed them on Resident #1's neck and head. Staff A stated the wet cloths helped briefly, but Resident #1 was back on her call light. One minute wanting in her bed and the next wanting back in her recliner. Staff A attempted to comfort her and told her they had given her medication that morning, but Resident #1 did not recall getting the medication. Staff A stated Resident #1</p>	F 684			

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F 684	Continued From page 39 was usually cognitively alert, could carry on a conversation, was independent with most care, and could walk independently using her walker. Resident #1 was also a nurse. Resident #1 continued to complain of a severe headache and Staff A stated she continued to report to the Administrator that Resident #1 was having an excruciating headache and requesting to be sent to the hospital. Staff A indicated the Administrator seemed more interested in cleaning and organizing the medication room than attending to the resident. By 12:00 p.m. to 12:30 p.m. Resident #1 became even more agitated and was yelling she needed to go to the hospital. Her outbursts were so disruptive that residents including Resident #2 and Resident #3, were also commenting to the Administrator that Resident #1 was crying and wanting to go to the hospital. Staff A stated Resident #1 was crying in pain and stated I was a nurse and this is not normal. Staff A stated Staff B and Staff C also witnessed Resident #1's cries for help that day, but nothing was done. Staff A stated she returned to work at 5:30 a.m. the following day (11/30/22). In report, the night aide reported Resident #1 continued to complain of pain and rolled out of bed. Resident #1 was not disturbed once she seemed to calm down. At around 6:20 a.m. Staff A checked on Resident #1. Resident #1 was soaked in urine from her shoulders to her knees. The nurse, Staff E witnessed the residents lack of care and instructed Staff A to give her a bed bath. Staff A stated once she began attending to Resident #1 she knew immediately that she had had a stroke. Resident #1 was unable to talk or move her right side. There was nothing in her eyes, she was like a vegetable. Staff E had an order for a urinalysis and she assisted him with getting the urine sample. Staff A commented, I believe she has	F 684			

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F 684	<p>Continued From page 40</p> <p>had a stroke and Staff E responded maybe. Staff A stated she changed Resident #1's bed three times that day and Resident #1 never showed any signs of improvement. Staff A stated on Monday, 11/28/22, Resident #1 was up, independent and in the dining room talking and normal and by Wednesday, 11/30/22 she was a vegetable.</p> <p>On 12/7/22 at 8:45 a.m. Staff A was contacted for clarification. Staff A stated that she gave a report to the on-coming aide (Staff G) at 2:00 p.m. on 11/29/22. Staff A stated she informed Staff G that Resident #1 had been up all night and complained of a severe headache throughout the day. Staff A stated Resident #1 was requesting to go to the hospital. Staff A explained that the Administrator knew of her condition and Resident #1's request to go to the hospital.</p> <p>In an interview on 12/5/22 at 4:55 p.m. Staff B, CNA, stated that she worked 6:00 a.m. to 2:00 p.m. on Monday, 11/28/22. Staff B stated she remembered Resident #1 being alert, conversing with staff, independently mobile using her walker, and being her normal self. Resident #1 only needed assistance with incontinence cares. On Tuesday, 11/29/22, Staff B worked from 6:00 a.m. until 2:00 p.m. That morning when she arrived, Resident #1 was complaining of a headache. As the morning progressed, Resident #1's headache worsened into a migraine. Resident #1 began requesting to be sent to the hospital. The Administrator stated they had already given her something and stated that is just Resident #1 she complains, but she is fine. Staff B stated she never saw the Administrator check on Resident #1. Resident #1 continued to complain of an excruciating headache and continually pulled on</p>	F 684			

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F 684	<p>Continued From page 41</p> <p>her call light throughout her shift. Resident #1 would say I was a nurse, I know they can help me, but no one did.</p> <p>On 12/7/22 at 11:50 a.m. Staff B was interviewed for clarification. Staff B stated when she spoke with the Administrator about Resident #1, she informed her that Resident #1 was requesting to go to the hospital. At that time the Administrator said she already gave her something for pain. The Administrator added that she complains, but she is fine.</p> <p>In an interview on 12/5/22 at 5:10 p.m. Staff C, Marketing, stated she arrived to work around 8:30 a.m. on 11/29/22. Several of the aides approached her with concerns related to Resident #1. The aides stated Resident #1 was complaining of an excruciating headache and requesting to go to the hospital. The aides indicated they had informed the Administrator several times, but she was doing nothing. Staff C stated she went to the Administrator and expressed her concern. The Administrator stated she had given Resident #1 a Tramadol (controlled pain medication) and they were getting an order for a urinalysis. Staff C stated that the Administrator never saw or assessed Resident #1 that day. Staff C stated that afternoon Resident #1 was grabbing at her head and screaming. Resident #1 wanted to go to the hospital. Staff C stated Resident #1 had been cognitively alert most of the day complaining of a headache, but by late that afternoon her speech had become garbled. She was not alert and confused. On Wednesday, 11/30/22, Resident #1's right side was flaccid, she was unresponsive, and she had no right-side vision. Staff C stated to her knowledge no one ever properly assessed</p>	F 684			

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F 684	<p>Continued From page 42</p> <p>Resident #1 or sought appropriate medical attention.</p> <p>On 12/7/22 at 8:08 a.m. Staff C was contacted for clarification. Staff C stated she included Resident #1's requesting to go to the hospital when informing the Administrator of Resident 1's condition that day and also reported late that afternoon when Resident #1's speech became garbled and she became confused.</p> <p>In an interview on 12/6/22 at 11:05 a.m. Staff D, Certified Medication Aide, stated she worked 6:00 a.m. to 2:00 p.m. on 11/29/22 and was assigned to pass medications. The scheduled nurse called in so the Administrator covered for the absent nurse. Staff D stated the Administrator remained in the medication room cleaning and organizing her entire shift. Staff D stated she started setting up medications when Resident #1's call light came on, so she responded. Resident #1 was complaining of a headache. Staff D assisted Resident #1 to the toilet. Resident #1 was having difficulties walking which was unusual for her. Staff D got Resident #1 to the toilet and returned to her medication cart. The call light came on again and Staff D returned and helped Resident #1 into her recliner, gave her a blanket. Moments later Resident #1 was hollering for help. Staff D gave her Tylenol at 7:14 a.m. and then again returned to her cart as Resident #1 continued to holler out and cry for help. Other aides voiced concerns. At around 9:00 a.m. Staff D asked the Administrator to check on Resident #1. Staff D stated the Administrator never checked on Resident #1 during her shift, despite being informed, and asked multiple times. Staff D stated she felt helpless because the Administrator would not do anything. Staff D stated she was on</p>	F 684			

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F 684	<p>Continued From page 43</p> <p>the assisted living unit setting up medications from about 10:00 a.m. until 12:00 p.m. Upon returning, Resident #1 was continuing to cry out in pain. Staff D said something to the Administrator and she was instructed to give Resident #1 Tramadol at 11:48 a.m. Staff D stated the Administrator did not assess Resident #1 prior to or after the administration of the controlled medication. The next day (11/30/22) an aide reported something was wrong with Resident #1. Staff D went to the room. Resident #1 was sitting in bed awake but not responsive, would not talk, and would not move. Resident #1 would not take her medications. Staff D reported her observations to Staff E. The Administrator was standing nearby, listening to the conversation, then stated the urinalysis was sent. And that she was fine. Staff F stated Staff E went to check on Resident #1.</p> <p>In an interview on 12/6/22 at 5:00 p.m. the Administrator stated on 11/29/22 the day nurse called in, so she took on the responsibilities of the licensed nurse from 6:00 a.m. to 6:00 p.m. The Administrator admitted she does not work the floor and was not familiar with the residents. The Administrator stated Resident #1 had a headache, was confused, and not acting right that day. Resident #1 was given as needed pain medication and the Administrator personally gave her pain medication at 6:02 p.m. The Administrator stated at one time that day (unable to specify the time of day) she noticed Resident #1's oxygen tubing knotted. She corrected it and checked the oxygen saturation which was at 91%-92%. The Administrator stated at 2:00 p.m. Staff D left, then at 6:00 p.m. Staff F arrived and took over the nursing duties. The Administrator was asked if anyone had approached her that day</p>	F 684			

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F 684	<p>Continued From page 44</p> <p>with concerns about Resident #1? The Administrator stated yes, they all thought she had COVID. They told her Resident #1 had a headache. The Administrator was asked if anyone told her Resident #1 wanted to go to the hospital? The Administrator stated no, if they had I would have sent her. The Administrator stated she never charted an assessment on Resident #1, consulted a physician, or notified family of Resident #1's condition.</p> <p>According to the Centers for Disease Control and Prevention (CDC) information on Stroke Signs and Symptoms dated March 4, 2022: During a stroke every minute counts, fast treatment can lessen the brain damage that stroke can cause. By knowing the signs and symptoms of a stroke, you can take quick action and perhaps save a life. Signs and symptoms of stroke include: *Sudden numbness or weakness in the face, arm, or leg, especially on one side of the body. *Sudden confusion, trouble speaking, or difficulty understanding speech. *Sudden trouble seeing in one or both eyes. *Sudden trouble walking, dizziness, loss of balance, or lack of coordination. *Sudden severe headache with no known cause. Call 9-1-1 right away if you or someone else has any of these symptoms.</p> <p>In an interview on 12/6/22 at 4:25 p.m. Staff G, CNA, stated she worked 2:00 p.m. to 10:00 p.m. on 11/29/22. In report she was informed that Resident #1 was not doing well, was in bed, and had a headache. Staff G stated Resident #1 was complaining of a major headache that evening and she informed Staff F, Licensed Practical</p>	F 684			

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OMB NO. 0938-0391

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F 684	<p>Continued From page 45</p> <p>Nurse (LPN). Staff G stated she assisted Resident #1 to the bathroom a couple times during her shift. Staff G stated Resident #1 was normally independent, so it was unusual for her needing assistance, but that evening she was having balance issues.</p> <p>In an interview on 12/7/22 at 10:30 p.m. Staff H, CNA, stated she worked the overnight shift (10:00 p.m. to 6:00 a.m.) on 11/28/22. Staff H recalled that Resident #1 slept through most of the night, but had slid out of bed at around 5:45 a.m. that morning. Staff H stated she noted no change in Resident #1's condition. Staff H stated she returned that evening (11/29/22) for the overnight shift and was informed in report Resident #1 had a headache that day and that they suspected she had a urinary tract infection. Staff H stated it was not unusual for Resident #1 to have headaches and receive Tylenol. Shortly after midnight (12:29 a.m.) Resident #1 was discovered on the floor in front of her recliner. Resident #1 was disoriented, saying what, what. Resident #1 was unable to understand or respond to staff. Staff H stated this was the first time she had noticed a dramatic change in Resident #1's condition who had been independent and required minimal assistance to now require total care, have to be checked for incontinence, and get changed as needed.</p> <p>In an interview on 12/8/22 at 12:50 a.m. Staff F stated she was an agency nurse, but has worked several shifts at the facility and was familiar with Resident #1. Staff F stated she worked the overnight shift (6:00 p.m. to 6:00 a.m.) on 11/28/22. Staff F recalled Resident #1 being fine during her shift. Resident #1 complained of a headache and was given Tylenol at 5:45 a.m. Resident #1 slid off of her bed when she sat up to</p>	F 684			

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F 684	<p>Continued From page 46</p> <p>take her medication. Resident #1 was not injured. On 11/29/22, Staff F returned to the facility to work another overnight shift. In report the Administrator stated Resident #1 had been acting differently and she was wanting to get a urinalysis and put in an order. The Administrator made no mention of Resident #1's complaints of headache that day or of her change in condition. Early that evening, Resident #1 was screaming help, help, help. Resident #1 was assisted to the bathroom and completely confused. Staff F stated she attributed the confusion to a urinary tract infection based on the information she was given from the Administrator. Staff F stated she thought the change in condition had already been discussed with a physician. Staff F stated if a resident had a change in condition, they should be assessed, have their vitals checked, and a physician notified. The assessment should be documented in the progress notes. Staff F stated she thought Resident #1's change in condition had already been reported.</p> <p>In an interview on 12/8/22 at 4:42 p.m. Staff E, LPN, stated he has taken care of Resident #1 for several years and knows the family well. Staff E stated 6 months ago Resident #1 went through a bout of pulmonary edema and hypoxia. During that time, she was hospitalized and upon returning to the facility she was placed on oxygen supplement and her condition was such that she was placed on hospice services. Resident #1 was adamant that she did not want to return to the hospital. Eventually Resident #1 recovered and about a month ago she was taken off hospice services. Resident #1 was able to toilet independently and required minimal assistance with care. Resident #1 used an oxygen supplement, but was not always compliant. Staff</p>	F 684			

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F 684	Continued From page 47 E stated he worked the day shift (6:00 a.m. to 6:00 p.m.) on 11/30/22. It was the first time he had worked in four days. In report he was informed by Staff F, that Resident #1 fell, had increased disorientation, agitation, and restlessness. Following the report, Staff E went to see Resident #1. One of the first things he noticed was a strong odor of urine. Staff E stated this was unusual as Resident #1 was normally a continent. Resident #1 was in her bed restless, grabbing her blankets, and throwing them off her bed. Resident #1 was not responding to directions and was saying words, but not every answer made sense. Staff E stated he checked her pupils which seemed equal and reactive to light, but was unable to check hand grips due to Resident #1's noncompliance. Staff E stated he also noticed Resident #1 holding her right arm into her body and her right wrist slightly contractured. Staff E stated they have a standing order for a urinalysis (UA), so he collected a urine sample to rule out a possible urinary tract infection (UTI). Meanwhile Staff E stated he knew the Advanced Registered Nurse Practitioner (ARNP) would be visiting that morning and she could assess Resident #1 further. At around 9:00 a.m. to 9:30 a.m. ARNP1 visited and started Resident #1 on an antibiotic. ARNP1 stated they would see whether Resident #1 had a UTI and if so treat accordingly. Otherwise the family needed to be consulted whether they wanted more aggressive treatment or comfort care. Staff E stated by the end of that day, Resident #1's right arm was pulled up against her body and right wrist contractured. At that time Staff E suspected Resident #1 had had a stroke. Staff E stated he contacted the family informing them of her condition and that she had probably had a stroke. The family stated they did not want her	F 684			

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F 684	<p>Continued From page 48</p> <p>hospitalized and if her condition did not change they would consider hospice. Staff E explained that according to other caregivers on 11/29/22, Resident #1 had an excruciating headache, unrelieved with medication throughout the day. She was continually on her call light and requesting to go to the hospital, Staff E stated he did not know that. Staff E stated Resident #1 putting on her call light or having a headache was not unusual, but not getting relief of her headache after receiving medication was unusual. Staff E asked what he would have done given these circumstances. Staff E stated he would have assessed Resident #1 and discussed what they could do to relieve her headache. If symptoms persisted he would notify the physician and have her sent out.</p> <p>In an interview on 12/6/22 at 10:05 a.m. ARNP1 reported that on 11/30/22 she visited the facility in response to Resident #1's change in condition. ARNP1 stated this was the first time she had ever seen Resident #1 and she was not familiar with the residents past abilities and condition. ARNP1 stated she was informed by Staff E that Resident #1 had become incontinent and her urine was foul smelling. Staff E stated Resident #1 gets confused when she has a urinary tract infection. ARNP1 stated she seen Resident #1 sitting at her bedside, restless, and unable to respond appropriately when spoken to. ARNP1 stated she spoke with her family who indicated they did not want Resident #1 sent to the hospital. The family indicated the resident would not want to go to the hospital. ARNP1 stated she had not been informed of Resident #1 was having an excruciating headache throughout the day on 11/29/22 and that Resident #1 was requesting to go to the hospital. ARNP1 stated she did not</p>	F 684			

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F 684	<p>Continued From page 49</p> <p>know that prior to the day before, Resident #1 was cognitively alert, verbal, and independently mobile using her walker. ARNP1 asked if she had been contacted about a resident having an excruciating headache, crying, and requesting to go to the hospital, would she send the resident? ARNP1 stated if the resident was cognitively aware, she would not hesitate to send her to the hospital. ARNP1 asked if a resident were having an excruciating headache 24 hours before she had an adverse condition change (stroke), would there have been any benefit to sending the resident to the hospital prior to those adverse changes. ARNP1 stated yes, there are medications which can slow the progression of a stroke down.</p> <p>In an interview on 12/7/22 at 11:30 a.m. the Director of Nursing (DON) stated she was at home with COVID on 11/29/22. The DON stated she has only been the DON for 3 weeks, but has worked at the facility for 3-4 months. The DON stated Resident #1 required limited assistance with changing and some care. Resident #1 could ambulate with a walker and could verbalize her wants and needs, although did not talk a lot. The DON indicated new nurses and CMAs are provided a job description upon hire and provided the surveyor the job descriptions for their CMAs, LPNs, and Registered Nurses. The DON stated residents with complaints or changes in condition are to be thoroughly assessed, treated, and documented in the progress notes. If a complaint persists or is a significant change, nurses are to contact a physician and treat accordingly. Families are also to be notified and documentation of actions recorded in the progress notes.</p>	F 684			

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F 684	<p>Continued From page 50</p> <p>According to the facilities undated Licensed Vocational Nurse Position Description (LPN), licensed nurses are responsible for:</p> <ul style="list-style-type: none"> *The total nursing care of residents in their assigned unit. *Assumes responsibility for compliance with Federal, State, Local and company regulations. *Charts progress notes in an informative, factual manner that reflects the care administered as well as the resident's response to care. *Observes residents, records significant conditions and reactions, notifies supervisor or physician of resident's conditions and reactions to drugs, treatments and significant incidents. *Takes temperatures, pulse, blood pressure and other vital signs to detect deviations from normal and assess the condition of the resident. *Responds to emergency situations based upon nursing standards, policies, procedures and protocols. <p>In an interview on 12/7/22 at 3:25 p.m. Staff I, LPN, stated that she works for an agency. Staff I stated when a resident has a complaint or change in condition, they are to be assessed, including checking vital signs, rating pain, and administering as needed (PRN) medications when appropriate. The assessment should be recorded in the progress notes. If the change in condition is significant or an emergency type situation, she would first attend to the resident's needs, consult a physician, and notify emergency medical services (EMS) if appropriate. Following the event, she would record the assessment and contact details in the progress notes or on an incident report form. Staff I stated she would notify family and record the communication in the progress notes. Staff I stated when giving a PRN medication, it is recorded in the electronic</p>	F 684			

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F 684	<p>Continued From page 51</p> <p>medical records (EMR) system. The EMR system automatically prompts a follow up needed to evaluate the effectiveness of the medication. Staff I stated she would usually wait 45 minutes to an hour and a half to revisit the resident and evaluate effectiveness. Staff I stated the follow up prompt will remain on the EMR until someone addresses it.</p> <p>According to Resident #1's progress notes: 11/28/22 at 8:16 p.m. administered 50 milligrams Tramadol HL as needed for a headache by Staff F. 11/28/22 at 11:04 p.m. recorded as effective by Staff F. 11/29/22 at 7:14 a.m. administered 650 milligrams of Tylenol as needed for a headache by Staff D. 11/29/22 at 11:25 a.m. recorded as effective by Staff D. 11/29/22 at 11:48 a.m. administered 50 milligrams of Tramadol HL as needed for a headache by Staff D. 11/29/22 at 5:53 p.m. recorded as effective by the Administrator. 11/29/22 at 6:02 p.m. administered 50 milligrams of Tramadol HL as needed for pain by the Administrator. 11/29/23 at 11:31 p.m. recorded as effective by Staff F.</p> <p>In an interview on 12/6/22 at 4:18 p.m. the primary care physician's nurse stated there was no record of anyone from the facility calling regarding Resident #1 on 11/29/22.</p> <p>On , the facility removed the immediate jeopardy, decreasing the scope to a D prior to the exit of the survey by</p>	F 684			

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F 684	Continued From page 52 a. When a resident voices a physical complaint and interventions are provided, the nurse will assess and document resolution of the symptoms. Prolonged symptoms will be reported to the medical doctor (MD) and family within two hours after interventions. b. The Charge Nurse will report to MD and family within two hours of interventions if physical symptoms are not improved. The Charge Nurse will document assessment and actions taken in progress notes and on 24 hour report. The 24 hour report and the progress notes will be reviewed Monday through Friday by the DON/designee and by the charge nurse on the weekends and will make changes in plan of care as indicated. c. The 24-hour report and progress notes will be used to address symptoms that residents report. d. The facility provided re-education to current nurses that when resident complains of symptoms, nurse must assess, document and provide interventions. When reassessing the residents, the nurse must document. If the interventions are ineffective, the nurse must call the MD and family within two hours. Immediate corrective action will include reviewing 24 hour report every Monday through Friday. The Weekend supervisor will review report and progress notes for change in status. The current licensed staff will be re-educated prior to working again with documentation of attendance.	F 684			